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Division of Health Care Facilities

RECEIVED
AUG 17 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 001	1200-08-25 Initial This Rule is not met as evidenced by: An annual and complaint survey was conducted at the facility on 5/21/12 to 5/23/12. Complaint #TN00029803 was investigated and was substantiated.	D 001	1. Licensed Nurses have been hired To administer all medications at Poplar Estates and The Garden's according to each Resident's plan of care the facility's medication policy. Each resident's medication list maintained in their chart has been reviewed and updated.	7/6/12
D 708	1200-08-25-.07 (5)(b) Services Provided (5) Resident medication. An ACLF shall: (b) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident ' s plan of care; and This Rule is not met as evidenced by: Based on facility policy, observation, medical record review and interview it was determined the facility failed to ensure medications were administered by professionally licensed staff for 3 of 3 (Caregiver #1, 2 and 4) sampled Caregivers observed during medication pass and/or interviewed. The findings included: 1. Review of the facility's Services Provided - Medication Policy revealed "[Named facility] shall...2. Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident's plan of care.	D 708	Medication Administration Records (MAR's) have been developed for each Resident according to their plan of care. The Director of Nursing will no longer prepare medications in advance as licensed nurses will be on-site to administer medications seven days per week. New medications or special orders will be documented in the residents' charts or care planned as needed. Medications given will be signed off on the MAR's by the Nurse on duty. 2. Nurses will be maintained on an on-going basis. The Executive Director will monitor for compliance The Director of Nursing will do random chart audits to assure compliance of documentation and administration of medications. 3. Date of Compliance will be July 6, 2012.	

Accepted 8/23/12 - PDC

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Executive NHA Director — (X6) DATE 6/18/12

Dawn K Kenny, NHA Executive Director 8/23/12

STATE FORM 6899 Y5DR11 If continuation sheet 1 of 19

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D 708	Continued From page 1 2. Observation of the medication pass on 5/21/12 in the Garden building (dementia unit) beginning at 7:00 PM revealed the following: Caregiver (CG) #1, put on gloves, went to an unlocked cabinet in the nursing station area removed an unlocked plastic box labeled "Monday" that contained rolls of individually pharmacy prepared packets labeled with the resident's name, date and time to be given and a list of the medications in each packet. The box also contained individual prefilled pill boxes, indentified with handwritten resident names. Observation of the pill boxes revealed they were labeled AM and PM. There was no identification of the medication, no date the medication was placed in the pill box or when the medication expired. CG #1 poured several cups of water and put them on the nurses' station desk that separated the kitchen and the common area of the facility, called the residents to the desk one by one, cut off the top of the resident's pill packet, poured the medication into the resident's open hand and gave them a cup of water to swallow the pills. For residents requiring medication from the pill boxes, CG #1 opened the PM pill cover and poured the pills in the resident's open hand and gave them water to drink. When CG #1 was asked to identify the medications she administered to Resident # 9 from the pill box, she stated "I don't know what all the pills are or what they are for, I think the little half one is Ativan. I don't know what the big white one is." Before going to Resident #1's room to give medications, CG #1 put on clean gloves, removed Resident's #1's medications from the plastic box, collected eye drops to be given from	D 708	4. The Director of Nursing and the Executive Director will report findings of their audits at the monthly Performance Improvement Committee meetings for six months of continuous compliance.	

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D 708	Continued From page 2 the unlocked cabinet, walked down the hall, opened the door to Resident #1's room. Wearing the same gloves, CG #1 removed a bottle of "Systane lubricant eye drops" from a plastic bag and put one drop in each eye. CG #1 then removed the gloves that were put on at the Nurses' station. Referring to a bottle of "Refresh Tears eye drops", CG #1 stated "I'm not sure which one of these (Resident #1) is suppose to get, but I don't ever give her these (Refresh), I always give these (Systane). When CG#1 was asked where to find out which eye drops were to be given, CG #1 stated "I'm not sure, but I think it's in that medication book." Before going into Resident #14's room, CG#1 put on clean gloves, gathered a medication packet with one gel capsule in it and a cup of water, walked down the hall and opened the door to the resident's room. To administer the one pill to Resident #14, CG #1 took the pill out of the pharmacy prepared packet, told the resident to open her mouth and then CG #1 put the capsule in the Resident #14's mouth. The resident did a brief chew of the capsule then took it out of her mouth and put it in the water cup. CG #1 stated "She always does that. She sucks the juice out of it and spits out the pill." Observation of the capsule at that time revealed it was not flat (as when all the medication is removed from gel capsules). CG #1 stated "I don't believe there is still medicine in it." Before leaving Resident #14's room, CG#1 removed the gloves put on at the nurses' station. Medical record review of Resident #1's Medication List revealed the following eye drops were to be given: Naphcon-A 1 gtt (drop) each eye qhs (before bedtime) and Systane gel drops 4-6 (symbol for times) a day. The list did not	D 708		

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D 708	Continued From page 3 document how many drops or into which eye the Systane gel drops were to be administered. Medical record review of Resident's #14's Medication List revealed the gel capsule administered by CG #1 was Depakote 250 milligrams (mg) qhs (every bedtime). Medical record review of the Medication Distribution Record (MDR) sheet documented the caregivers initials and if medications were given at 8:00 AM, 12 Noon, 5:30 PM or 8:00 PM . The MDR did not document the name of the medications given, the dose given, changes in medications, vital signs if indicated, or indicate if medications were missed or refused. The MDR also did not document if Insulin was given or how much. The facility could not produce documentation that information not documented on the MDR was documented anywhere in the resident's medical record. Medical record review of the Medication List, found in each resident's chart, revealed 4 of 6 Medication List reviewed was either incorrect or not updated. During an interview with CG #1 at the Garden's Nurses station on 5/21/12 at 5:45 PM, CG #1 stated "I don't put medications together, they come in little packets. If someone needs a narcotic, they are in the lock box on the counter. CG #1 pointed to a small metal box on the counter behind the nurses' counter. CG #1 opened the metal box with a key and showed the surveyor small packets of Lortabs that had the name of the medication and the resident's name either hand printed or typed on a label. Observation of the packets revealed there was no date the medication were put in the packets or	D 708		

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D 708	Continued From page 4 expiration date. CG #1 stated "[Named Director of Nursing] (DON) puts them in the packets usually about 10 at a time and we take them out as we need them. I don't have anyone that needs a patch now, but I put medication patches on the residents. I do finger sticks to check the resident's blood sugar if they need it." 3. During an interview with CG #2 in the sunroom of the Poplar Building on 5/22/12 at 2:50 PM, CG #2 stated "Yes, I give medications. I only have to crush medications for (Random Resident RR #10). I crush the medications and put them in diabetic jelly and take it to her. If I or a resident drops a pill, I can tell by the color the name of the medication. If it's white, I tell by the shape, what pill it is. I just pull that pill from the next day's medication. Then I call the (DON) or the Medical Assistant (MA)to tell them. (RR #11) gets Lortab. If she needs it, I just get it from the lock box in a packet with her name on it. I don't pour them; they might spill so I just reach in the bag and get one. If she is in the dining room, I just take it to her in my hand and drop it in her hand. 4. During an interview with CG #4 in the sunroom of the Poplar Building on 5/22/12 at 7:28 PM, CG #4 stated "Yes, I give medications. I give (Resident #4) her insulin. They want to keep it (blood sugar) in the 240's. If it's higher, I keep an eye on her. Call (DON) if it goes over 300. Low is 120 or less, if it's that low it would concern me because she runs high. She might be able to check her blood sugar if someone was standing over her, but I don't think she can." During an interview with Resident #4 in the resident's room on 5/22/12 at 7:20 PM, Resident #4 stated "They give me a shot in my belly. I think it's every day. I don't ever give it to myself. Whoever is working that day gives me the shot.	D 708		

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D 708	Continued From page 5 They stick my fingers often." 5. During an interview with the DON in the DON's office on 5/22/12 at 10:10 AM, the DON confirmed that the Caregivers administered medications. The DON also said he stopped using Medication Administration Records (MAR) because they were too much trouble and he did not want to document that he was giving medications that he was given by someone else. During and interview with the DON, at the nurses' station in the Gardens building, on 5/22/12 at 10:50 AM, the DON said he had prepared two weeks' worth of medication in advance because he was going on vacation. One week of resident medications was at the nurses' station in the cabinet and the other week was in the MAs Office. (The MA was also a caregiver.) During an interview with the DON in the sunroom on 5/22/12 at 5:10 PM the DON confirmed there was no documentation that new medications were given as ordered, that insulin was given or how much, or that special physician medication orders were followed. When the DON was asked how new or special orders for medications were communicated to the CGs, he stated "I tell them." The DON also said he knew medications were given because they weren't there (in the medication boxes). When the DON was asked how he could prove if the verbal orders given to the CGs were being followed he stated "I can't prove it."	D 708		
D 710	1200-08-25-.07 (6)(a) Services Provided (6) An ACLF shall dispose of medications as follows:	D 710		

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D 710	Continued From page 6 (a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider. This Rule is not met as evidenced by: Based on facility policy review, observation and interview it was determined the facility failed to properly dispose of discharged residents' medications for 3 of 3 (Resident #6, Random Resident #1 and Random Resident #9) discharged charts reviewed. The findings included: 1. Review of the facility's Services Provided - Medication Policy revealed "[Named facility]shall dispose of medications as follows: 1. Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authoized healthcare provider." 2. During observation of Medication Cart #2 for the Garden residents on 5/22/12 beginning at 9:15 AM the following medications, individually pharmacy packaged according to the resident's name and date and time to be given, were observed: Resident #6 - (Each medication is one tablet unless otherwise specified) Amlodipine 5 milligrams (mg), Carvedilol 3.125mg, Gabapentin 300mg, Isosorbide DIN 20mg, Lipitor 40mg, Omeprazole ER 20mg, Oyst-Cal - 500mg,	D 710	1. The Director of Nursing has inspected both medication carts and has disposed of all expired medications. 7/6/12 2. The Director of Nursing and the licensed nurses will do weekly inspections of the medication carts for expired medications to ensure all expired medications have been removed and properly disposed of. 3. Date of Completion will be July 6, 2012. 4. Director of Nursing will report findings of weekly cart inspections to the monthly Performance Improvement Committee for three months of continuous compliance.	

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D 710	Continued From page 7 Sulfadiazine 500mg, Trazodone 50mg and Trazodone 100mg. Additionally, the medication package was labeled to expire April 2012. RR #1 - Levathyroxine 88 mcg (micrograms), Lisinopril 30mg, Metformin HCL 1000mcg, Buspirone 10mg, Docusate Sodium 100mg, Lovastin 40mg, Metformin HCL 1000mg. Additionally, the expiration date was January 2012. RR #9 - Diclofenac DR 75mg - 20 tablets. Additionally, the expiration date was 3/7/11. 3. During an interview with the Director of Nursing (DON) present during the observation of the medication carts, the DON initially said the medications were not disposed of "just in case someone drops a pill and I need to replace it." Later in the interview the DON said he was "not keeping them for any reason, I'm just not cleaning them out (of the medication cart)."	D 710		
D 712	1200-08-25-.07 (6)(c) Services Provided (6) An ACLF shall dispose of medications as follows: (c) Any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional. This Rule is not met as evidenced by: Based on facility policy review, observation and	D 712		

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D 712	Continued From page 8 interview it was determined the facility failed to destroy expired medications for 8 of 50 (Resident #8 and Random Residents (RR) #2, #3,#4,#5,#6,#7 and #8) current residents in 2 of 2 medication carts observed. The findings included: 1. Review of the Services Provided - Medication Policy revealed "3. Any non scheduled drug that is misbranded, expired deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at [named facility]in the presence of another licensed or certified professional." 2. During observation of Medication Cart #1 for the Popular residents on 5/22/12 beginning at 9:15 AM revealed the following medications, individually pharmacy packaged according to the resident's name and date and time to be given, were expired for: RR #3 - (Each medication is one tablet unless otherwise specified) Aspirin 81 milligrams (mg), Avadart 0.5mg, Buspirone 5mg, Buspirone 5mg - 1/2 tab (tablet), Docusate Sodium 100mg, Ferrous Sulfate 325mg, Fexofenadine 180 mg, Glycopyrolate 1mg, Klor-Con 10 millequivalents (meq), Metformin 500 mg, Metoprolol 25mg, Omeprazole ER 20mg, Oyst-Cal 500mg, Forsemide 10mg, Vitamin B-12 1000 micrograms (mcg) and Vitamin C 500mg. The medication package was labeled to be given 10/19/11 and expires April 2012. RR #4 - (Each medication is one tablet unless otherwise specified) Amlodipine 2.5mg and Citalopram 10mg. The medication package was labeled to be given 10/19/11 and expires April	D 712	1. The Director of Nursing has inspected both Medication Carts and removed and properly disposed of all medications that have been discontinued and for all discharged residents. 2. The Director of Nursing and the licensed nurses will do weekly inspections of both medication carts for discontinued medications and for medications of discharged residents. Such medications will be removed and properly disposed of according to the facility medication policy. 3. Date of Completion will be July 6, 2012. 4. The Director of Nursing will report findings of weekly cart inspections to the Performance Improvement Committee for three months of continuous compliance.	7/6/12

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D 712	Continued From page 9 2012. RR #5 - (Each medication is one tablet unless otherwise specified) Docusate Sodium 100mg, Furosemide 40mg, Furosemide 20mg, Lisinopril 5mg, Nexium 40mg, Potassium Chloride 20meq, Citalopram 20mg, Docusate Sodium 100mg, Donepezil 10mg and Warfarin 7.5 mg. The medication package was labeled to be given 10/19/11 and expires April 2012. RR #6 - Cyanocoblamin 10 milliliters (ml) 1000mcg/ml, was opened not dated with an expiration date of January 2012. RR #7 - (Each medication is one tablet unless otherwise specified) Amlodipine 5mg, Divalproex ER 250mg, Hydrochlorothize 12.5mg, Namenda 10mg, SOys-Cal D 500mg, Quinapril 40mg, Divalprorex ER 250 mg, Melatonin 3mg, Mirtazapine 45mg, Namenda 10mg, Pravastatin 40mg and Quinapril 40mg. The medication package was labeled to be given 10/19/11 and expires April 2012. RR #8 - (Each medication is one tablet unless otherwise specified) Carvedilol 6.25mg, Digoxin - 125mcg, Docusate Sodium 100mg, Furosemide 40mg, Meloxican 7.5mg, Namenda 10mg, Mirtazapine 30mg, Namenda 10mg, Seroquel 50mg - 2 tablets, Warfarin 1mg. The medication package was labeled to be given 10/19/11 and expires April 2012. 3. During observation of Medication Cart #2 for the Garden residents on 5/22/12 beginning at 9:15 AM revealed the following medications, individually pharmacy packaged according to the resident's name and date and time to be given, were expired for:	D 712		

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D 712	Continued From page 10 Resident #8 - Dilt-XR 180mg - 6 tablets and Rantidine 75 mg - 6 tablets with expiration date of 4/26/11. RR #2 - Hydroxyzine 50mg - 20 tablets- expiration date 4/26/12 and Cyanocobalmin 1000mcg/ml - expiration date 11/4/2011. 4. During an interview with the Director of Nursing (DON) present during the observation of the medication carts, the DON initially said the medications were not disposed of "just in case someone drops a pill and I need to replace it." Later in the interview the DON said he was "not keeping them for any reason, I'm just not cleaning them out (of the medication cart)." Regarding Resident #8 and RR #2,s expired medications, the DON stated "those are just left overs."	D 712		
D1216	1200-08-25-.12 (3)(g) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes; This Rule is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure that residents' medical records included identification	D1216		

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D1216	Continued From page 11 of outside agencies providing care for the residents in the facility and failed to ensure residents' medical records included progress and nursing notes from those agencies for 1 of 1 (Resident #5) sampled resident receiving services from an outside agency. The findings included: During the entrance conference on 5/21/12 at 4:45 PM, the surveyor asked the Medical Assistant (MA) for a list of resident receiving services from outside agencies. During an interview with the Medical Assistant (MA) in the hallway on 5/22/12 at 9:05 AM the MA stated "I don't have a list of Resident's with outside services, but I'm working on it." Medical record review documented Resident #5 was admitted to the facility on 8/5/11 with diagnoses that included Dementia, Coronary Artery Disease, Hypertension, Diverticulitis and Bilateral Lower extremity Edema. Review of a physicians note dated 8/8/11 documented to check with (Named Home Health Agency) regarding Resident #5's last Pneumonia vacination. Review of Resident #5's medical record revealed no documentation of Home Health services and no Care Plan, Progress Notes or Nurses' Note from the HHA. Prior to surveyor request the facility did not maintain a list of residents receiving services from outside agencies. During an interview with the Director or Nursing (DON) in the hallway on 5/22/12 at 1:15 PM, the	D1216	1. Facility has contacted current outside service providers to request that progress notes be written upon each resident visit in the resident medical record. 2. Director of Nursing will audit resident medical records monthly to assure compliance. 3. Date of Completion will be July 6, 2012. 4. Director of Nursing will report findings of monthly audits to the Performance Improvement Committee for three months of continuous compliance.	7/6/12

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1216	Continued From page 12 DON was asked how he knew about the progress of the resident's receiving Home Health. The DON stated "They give me a verbal report if they need me to know something, but it's not documented anywhere."	D1216		
D1218	1200-08-25-.12 (3)(i) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (I) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death; This Rule is not met as evidenced by: Based on medical record review and interview it was determined the facility failed to ensure the medical records included discharge information for 1 of 1 (Resident #6) discharged records reviewed. The findings included: Medical record review for Resident #6 revealed the resident was admitted to the facility on 3/18/09. During observation of the medication carts, Resident #6 was identified as discharged. There was no documentation in Resident #6's medical record of the date, time and under what circumstances the resident was discharged. During an interview with the Administrator in the	D1218	1. A nurse's note will be written for each discharge of each resident reflecting time, condition of resident and circumstances of each discharge. 2. Director of Nursing will audit resident medical records monthly for compliance. 3. Date of Completion will be July 6, 2012. 4. Director of Nursing will report findings to the Performance Improvement Committee for three months of continuous compliance.	7/6/12

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

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D1218	Continued From page 13 Director of Nursing's office on 5/22/12 at 7:59 PM, the Administrator stated "I don't see why we have to write a discharge summary in the chart for residents. We know what happened to our Residents, we discuss it in our Performance Improvement meetings".	D1218		
D1223	1200-08-25-.12 (5)(a) Resident Records (5) Plan of care. (a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident ' s legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals. This Rule is not met as evidenced by: Based on review of facility Incident/Accident and Investigation records, medical record review, observation and interview it was determined the facility failed to update care plans to address special needs for 4 of 6 (Resident #2, #3, #4 and #5) sampled residents and failed to complete care plans at least semiannually for 5 of 6 (Resident #2, #3, #4, #5, and #6) sampled residents. The findings included: 1. Medical record review revealed Resident #2 was admitted to the facility on 12/2/2010 with diagnoses that included Alzheimer's Dementia, Agitation, Psychosis, and Depression.	D1223	1. Care Plans have been updated and will be maintained semi-annually (quarterly for those in the secured unit). Updates will also be made as changes in resident conditions and/or new needs occur. 2. All changes to the care plans will be reviewed and discussed monthly in the Performance Improvement Committee meetings. Care Plans will be audited at that time for compliance by the Performance Improvement Committee. 3. Date of Completion will be July 6, 2012. 4. The Performance Improvement Committee will monitor for on-going compliance at their monthly meetings.	7/6/12

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

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D1223	Continued From page 14 Observation of the Gardens Building's (dementia unit) residents on 5/21/2012 beginning at 5:45 PM revealed Resident #2, Caregiver (CG) #1 and three other residents were sitting at the dining table. CG #1 was encouraging Resident #2 to eat. Resident #2 became agitated and to begin hit CG #1 on the hands. As CG #1 attempted to redirect Resident #2, Resident #2 attempted to hit CG #1 in the face. CG#1 stopped Resident #2 from hitting her by holding the Resident's wrist as it came close to her face. Resident #2 was also observed walking around the common area mumbling and agitated, using profanity while standing over another resident's chair and was observed going into another resident's room and slamming the door. Review of the facility Incident/Accident Reporting and Investigation records documented on 2/13/2012 " [named Resident # 2] tried to take [named another resident's] food and hit her [named other resident's] right arm." Review of an incident on 3/16/2012 documented "Staff took [named Resident # 2] into her room to get changed, she was refusing and fighting, then fell on floor on [symbol for right] side. No signs of any bruises." Neither incident documented recommended interventions for the resident's behavior were developed following the incidents. There was no documentation in the Nurses' Notes regarding the incidents. Review of Resident #2's Care Plans dated 12/2/2010 and 3/20/2012 did not identify behavior problems. There was no documentation the Care Plan was updated between 12/2/2010 and 3/20/2012. 2. Medical record review documented Resident #3 was admitted to the facility on 4/1/2010 with	D1223		

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

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D1223	Continued From page 15 diagnoses that included Dementia, Diabetes Mellitus, and Hypertension. Observation of the Gardens Building's residents on 5/21/2012 beginning at 5:45 PM revealed Resident #3 had a large bruise to the left side of her face, bruises on her arms and left hand. Two caregivers were attempting to help Resident #3 ambulate from her room to a chair in the common area and Resident #3 was spitting at the caregivers. The Administrator, present at the time of the interaction, stated "She will spit at the staff." Review of the Incident/Accident Reporting and Investigation records dated 1/28/2012 documented, "[named Resident #3] hit [named another resident] on the wrist. Has a bruise in the area. Review of an incident report dated 3/16/2012 documented, "[named Resident #3] sat in a chair with another resident already sitting there... [named other resident] pushed [named Resident #3] off her into the floor, no bruises." Review of an incident report dated 5/20/2012 documented, "I was taking [named Resident #3] to the BR [bathroom]. She bumped her arm on the potty chair arms. Left arm now has a skin tear...." In response to the question, "What was the Resident's Mental Status Prior to Incident?" the writer documented, "normal/fighting." There were no documented interventions for the resident's behavior following the incidents. There was no documentation in the Nurses' Notes regarding the incidents. Review of Resident #3's current Care Plan dated	D1223		

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Division of Health Care Facilities

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

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D1223	Continued From page 16 4/2/2012 documented no behavior problems. Review of all incidents for 2012 for Resident # 3 revealed the resident had 10 incidents of falls since the beginning of 2012. There were no care plan updates to address the falls. There was no documentation the Care Plan was updated between 4/1/2010 and 4/2/2012. During a telephone interview with the DON on 5/23/2012 at 1:30 PM, the DON stated (Resident #2) "has had aggressive behaviors toward other residents in the past. She has been seen by psyche nursing in the past, but not recently... (Resident #3) can be aggressive too. I don't think she has been aggressive towards residents, but I'm not sure. I don't think she has been seen by psyche." The DON confirmed there were no nurses' notes or Care Plans addressing Resident #2 and #3's behaviors. 3. Medical record review documented Resident #4 was admitted to the facility on 11/26/2009 with diagnoses that included Congestive Heart Failure, Type 2 Diabetes Mellitus, and Coronary Artery Disease. Review of Resident #4's Medication List dated 6/16/2011 documented Lantus (Insulin) 66u (units) qd (every day). A physician's order dated 6/24/2011 ordered, "Please [symbol for increase] Lantus to 74 u QD. Fax BS [blood sugar] readings in 10 days. A physician's order dated 7/7/2011 ordered "Fax Sugar Readings q (every) 2 weeks." A physician's order dated 5/14/2011 ordered, "Change Lantus to 54 u every morning and 24 units every evening. A clarification order, not dated, ordered Lantus 50u q AM, 10u qhs (every bedtime). The current Medication List	D1223		

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

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D1223	Continued From page 17 dated 1/11/2012 documented the resident was to receive Lantus 50u q AM and Lantus 10u qhs. Review of the finger stick blood sugar (FSBS) log for 5/1/12 to 5/22/12 documented Resident #4 had three FSBS results greater than 300. There was no documentation of follow up after these readings of over 300. The facility provided no documentation that the insulin changes were implemented or that finger stick blood sugar results were faxed to the doctor as ordered. Review of Resident #4's Care Plan dated 4/2/2012 revealed no documentation to address Resident #4's changing insulin needs. There were no care plans for Resident #4 for the year of 2011. There was no documentation of Care Plan updates between 7/20/2010 and 4/2/2012. 4. Medical record review documented Resident #5 was admitted to the facility on 8/5/2011 with diagnoses that included Dementia, Coronary Artery Disease, Hypertension, Diverticulitis, Chronic Statis Edema, Neuropathy Lower Extremities, Osteopenia and Sciatica Right Hip. Review of a physician's note to the facility, not dated but noted by the Director of Nursing on 12/7/2011, documented, "Problem recently was elevated blood pressures. Heart failure because of elevated blood pressures. Blood pressure goal < [symbol for less than] 130/80. Ask nurses - Assisted Living to [symbol for check] B/P [blood pressure] weekly - record. If we see more than 2/10 blood pressure elevation, then add Clonidine 0.1 mg [milligram] each evening." There was no documentation the Clonidine was added to the medication list or given for elevated blood	D1223		

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	TNPL53777	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D1223	Continued From page 16 pressures. Review of the May, 2012 daily Blood Pressure Log for Resident #5 documented a B/P on 5/19/2012 of 173/70 and on 5/20/2012 a B/P of 200/79. There was no documentation the physician was notified of the elevated blood pressure readings. There was no documentation of communication between the Home Health Agency (ordered for disease management) and the facility. Resident # 5's Care Plan was not updated to address High B/P. There was no documentation of Care Plan updates between 8/5/2011 and 3/22/2012. 5. Medical record review revealed Resident #6 was admitted to the facility on 3/18/2009 with diagnoses that included Chronic Ischemic Heart Disease, Hypertension, Chronic Airway Obstruction, Osteoporosis, Rheumatoid Arthritis, and Hyperlipidemia and was discharged on 1/23/2012. There was no documentation of a Care Plan update during 2011. 6. During an interview with the DON and the Medical Assistant (MA) in the DON's office on 5/22/2012 at 7:50 PM, the MA stated "We are trying to catch up on our Care Plans." The MA and the DON confirmed there were no Care Plans for the year 2011. The DON confirmed there were no Care Plans updates.	D1223		

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	TNPL53777	A. BUILDING 02 - STATE BUILDING B. WING _____	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

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D 901	1200-08-25-.09 (1) Building Standards (1) An ACLF shall construct, arrange, and maintain the condition of the physical plant and the overall ACLF living facility environment in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the overall physical environment. The findings included: On 5/22/12 at 1:20 PM, observation within room 113 bathroom revealed the exhaust fan grille was dirty. This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 5/22/12.	D 901	1. The exhaust fan grille in Room 113 was cleaned 2. The cleaning of the exhaust fan grilles have been placed on the weekly cleaning list of the housekeeper 3. This was completed on June 4, 2012 4. The Director of Maintenance will pick 6 random rooms weekly and report monthly to the Performance Improvement Committee for three months of continuous compliance.	6/4/12
D1001	1200-08-25-.10 (1) Life Safety (1) The department will consider any ACLF that complies with the required applicable building and fire safety regulations at the time the Board adopts new codes or regulations, so long as such compliance is maintained (either with or without waivers of specific provisions) to be in compliance with the requirements of the new codes or regulations. This ELEMENT is not met as evidenced by: Based on observations, it was determined the facility failed to comply with applicable building	D1001	RECEIVED	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Executive Director — (X6) DATE

STATE FORM 6899 Y5DR21 If continuation sheet 1 of 4

E-MAILED
6/13/12 — PDC

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53777	A. BUILDING 02 - STATE BUILDING B. WING _____	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D1001	Continued From page 1 and fire safety regulations. The findings included: 1. On 5/22/12 at 11:00 AM, observation within the side door corridor area revealed there was a through penetration in the corridor wall. 2. On 5/22/12 at 11:35 AM, observation within the mechanical room of the Garden Apartment area revealed a penetration around a cable in the sheet rock ceiling. 3. On 5/22/12 at 1:30 PM, observation within the elevator room revealed there was a though penetration in the fire rated door. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 5/22/12.	D1001	1. The penetration in the corridor wall within the side door corridor area was repaired. The Penetration around a cable in the sheet rock ceiling within the mechanical room at The Garden's was repaired. The penetration in the fire rated door within the elevator room was repaired. 2. When work is done, causing penetrations in walls, doors or ceilings, the Director of Maintenance will assure that all penetrations have been caulked with a fire caulking substance. 3. This was completed on June 6, 2012. 4. The Director of Maintenance will report repair completions to the Performance Improvement Committee.	6/6/12
D1024	1200-08-25-.10 (5)(c) Life Safety (5) An ACLF shall take the following precautions regarding electrical equipment to ensure the safety of residents: (c) Maintain all electrical equipment in good repair and safe operating condition; This Rule is not met as evidenced by: Based on testing and observations, it was determined the facility failed to maintain the electrical equipment. The findings included:	D1024		

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	TNPL53777	A. BUILDING 02 - STATE BUILDING B. WING _____	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D1024	Continued From page 2 1. On 5/22/12 at 11:15 AM, observation within resident room 102 revealed a broken outlet cover plate. 2. On 5/22/12 at 1:00 PM, testing of the emergency light in the dining room area within the Garden Apartment reveled one of the lights did not work. 3. On 5/22/12 at 1:12 PM, testing of the Ground Fault Circuit Interrupter outlet in room 207 revealed the unit was not working. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 5/22/12.	D1024	1. The broken outlet cover in Room 102 was replaced. The emergency light in the dining area at the Garden's was replaced. The GFC outlet in Room 207 was repaired. 2. The Director of Maintenance will check outlets and replace light bulbs on his weekly maintenance checks for proper operation. 3. These items were repaired/replaced on June 4, 2012. 4. The Director of Maintenance will monitor for three months of continuous compliance and report to the Performance Improvement Committee at their Monthly Meeting.	6/4/12
D1034	1200-08-25-.10 (7) Life Safety (7) An ACLF shall not allow trash and other combustible waste to accumulate within and around the ACLF. It shall store trash in appropriate containers with tight-fitting lids. An ACLF shall furnish resident sleeping units with an UL approved trash container. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to provide UL approved trash containers. The findings included: 1. On 5/22/12 at 12:00 PM, observation within resident room 13 in the Garden Apartment area revealed the use of non UL approved trash container. 2. On 5/22/12 at 1:15 PM, observation within	D1034	1. The trash cans in Room 13 and Room 210 were replaced with UL approved trash cans. 2. The Director of Maintenance will assure that all trash cans are of the UL rating on his weekly Maintenance Checks. 3. This was completed by June 8, 2012. 4. The Director of Maintenance will report his findings to the Performance Improvement Committee at their Monthly Meetings.	6/8/12

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	TNPL53777	A. BUILDING 02 - STATE BUILDING B. WING _____	05/22/2012

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D1034	Continued From page 3 resident room 210 revealed the use of non UL approved trash can. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 5/22/12.	D1034		
D1035	1200-08-25-.10 (8)(a) Life Safety (8) An ACLF shall ensure that: (a) The ACLF maintains all safety equipment in good repair and in a safe operating condition; This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain safety equipment in good condition. The findings included: On 5/22/12 at 11:21 AM, observation within resident room 101 revealed the closet sprinkler was flush with the ceiling. This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 5/22/12.	D1035	1. The closet sprinkler in Room 101 was repaired. 2. The Director of Maintenance will inspect all sprinkler heads to insure proper placement on his weekly Maintenance Rounds. 3. This was completed June 8, 2012. 4. The Director of Maintenance will report his findings to the Performance Improvement Committee. RECEIVED	6/8/12

RECEIVED

AH Form Approved
6/26/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
TNPL53777	A. Building B. Wing 02 - STATE BUILDING	6/25/2012

Name of Facility	Street Address, City, State, Zip Code
POPLAR ESTATES RETIREMENT CENTER	1310 ROSEWOOD DRIVE COLUMBIA, TN 38401

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix D0901 Reg. # 1200-08-25-.09 (1) LSC	06/04/2012	ID Prefix D1001 Reg. # 1200-08-25-.10 (1) LSC	06/06/2012	ID Prefix D1024 Reg. # 1200-08-25-.10 (5)(c) LSC	06/06/2012
ID Prefix D1034 Reg. # 1200-08-25-.10 (7) LSC	06/06/2012	ID Prefix D1035 Reg. # 1200-08-25-.10 (8)(a) LSC	06/06/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date: 6.26.12	Signature of Surveyor:		Date: 6/25/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:		Date:

Followup to Survey Completed on: 5/22/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO